

LIMITED AUTHORIZATION TO DISCLOSE AND HEALTH INFORMATION
(Pursuant to the Health Insurance Portability and Accountability Act "HIPAA" of 4/14/03)

TO:

Patient Name:

DOB:

SSN:

I, _____, hereby authorize you to release and furnish to:
The Marker Group at 13105 Northwest Freeway, Suite 300, Houston, Texas 77040, copies of the following information:

- * All medical records, including inpatient, outpatient, and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians. Said medical records shall include all information regarding AIDS and HIV status.
- * This authorization does allow the release of mental health or other psychiatric records, unless this box is checked ☐
- * All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.
- * All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- * All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
- * All Worker's Compensation records, Social Security and disability records.
- * All billing records including all statements, itemized bills, and insurance records.
- * All employment records, including attendance reports, performance reports, W-4 forms, W-2 forms, medical reports and/or any and all other records relating to my employment, past and present.

1. To my medical provider: **this authorization is being forwarded by, or on behalf of, attorneys for the defendants for purposes of litigation. You are not authorized to discuss any aspect of the above-named person's medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on his or her medical or physical condition, unless you receive an additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the medical records, or any other matter bearing on my medical or physical condition at a deposition or trial.**
2. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
3. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will remain in effect until 4 years from the date of this authorization.

4. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above.
5. A notarized signature is not required. CFR 164.508. A copy of this authorization may be used in place of an original.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Date: _____

(Signature) Patient or Patient Representative

Printed Name of Patient's Representative

Description of Representative's authority to act for patient
/relationship to patient (if applicable)

Patient's Name and Address:

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.